



Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity and Fee Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier	
Requestor's Name and Address: Allied Multicare Centers 415 Lake Air Drive Waco, Texas 76710	MDR Tracking No.: M5-06-0179-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: American Home Assurance, Box 19	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 form, Explanations of Benefits, medical documentation and CMS 1500's. Position summary states, "The employee is specifically entitled to health care that cures or relieves the effects naturally resulting from the compensable injury, promotes recovery, or enhances the ability of the employee to return to or retain employment."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 response and Explanations of Benefits. Position summary states, "No further payment was recommended towards the amount in dispute."

PART IV: SUMMARY OF DISPUTE AND FINDINGS - Medical Necessity Services

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
10-1-04 – 10-11-04	CPT codes 98940, 98941, 97124, 97530, 97110, G0283	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$490.83
10-13-04 – 1-31-05	CPT codes 97012, 97112, 98940, 98941, 97124, 97530, 97110, G0283	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code and Division Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), Medical Dispute Resolution assigned an Independent Review Organization (IRO) to conduct a review of the medical necessity issues between the requestor and respondent.

The Division has reviewed the enclosed IRO decision and determined that the requestor did not prevail on the majority of the disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is \$490.83.

Based on review of the disputed issues within the request, the Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by Medical Dispute Resolution.

On 10-21-05 the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

CPT code 97112-GP on 9-27-04 and 9-29-04 is a fee issue - the insurance carrier denied it as “F-435 - the value of this procedure is included in the value of the comprehensive procedure.” This service is considered by Medicare to be a component procedure of CPT code 98941. Recommend no reimbursement.

CPT code 97110-GP on 10-1-04, 10-4-04, 10-6-04, 10-8-04 and 10-11-04, 10-20-04, 10-29-04, 11-1-04 and 11-3-04 was denied by the carrier as “710-The charge is being disallowed as supporting documentation is required to clarify services rendered” or as “713-The charge exceeds the scheduled value and/or parameters that would appear reasonable.” Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, Medical Review has reviewed the matters in light all of the requirements for proper documentation. MR declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. Reimbursement not recommended.

CPT code 97530-GP (4 units) on 10-20-04 and 10-29-04 was denied by the carrier as “710-The charge is being disallowed as supporting documentation is required to clarify services rendered.” The requestor provided documentation to support delivery of services per Rule 133.307(g)(3)(A-F). Recommend reimbursement of \$277.20 (\$34.65 X 8 units).

CPT code 98941 on 10-29-04 was denied by the carrier as “710-The charge is being disallowed as supporting documentation is required to clarify services rendered.” The requestor provided documentation to support delivery of services per Rule 133.307(g)(3)(A-F). Recommend reimbursement of \$43.64.

CPT code 97530-GP on 11-01-04 and 11-3-04 was denied by the carrier as “713-The charge exceeds the scheduled value and/or parameters that would appear reasonable.” The carrier made no payment and gave no valid reason for not doing so. Recommend reimbursement of \$69.30 (\$34.65 X 2 DOS).

CPT code 97112-GP on 11-1-04 and 11-3-04 was denied by the carrier as “713-The charge exceeds the scheduled value and/or parameters that would appear reasonable.” The carrier made no payment and gave no valid reason for not doing so. Recommend reimbursement of \$68.60 (\$34.30 X 2 DOS).

CPT code 97110-GP on 11-24-04, 11-29-04 and 12-1-04 was denied by the carrier as “213-The charge exceeds the scheduled value and/or parameters that would appear reasonable.” Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Division has reviewed the matters in light all of the requirements for proper documentation. MR declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. Reimbursement not recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 133.307(g)(3)(A-F) and 134.202(c)(1).

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. 413.031, the Division has determined that the requestor is not entitled to a refund of the paid IRO fee. The Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute in the amount of \$949.57. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 30 days of receipt of this Order.

Findings and Decision and Order by:

Donna Auby

12-20-05

Authorized Signature

Typed Name

Date of Order

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Appeals of medical dispute resolution decisions and orders are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. 413.031(k), as amended and effective Sept. 1, 2005]. An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. The Division is not considered a party to the appeal.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

December 6, 2005

November 22, 2005

TDI, Division of Workers' Compensation
Medical Dispute Resolution
Fax: (512) 804-4868

Re: Medical Dispute Resolution
MDR #: M5-06-0179-01
DWC#:
Injured Employee: ____
DOI: ____
SS#: ____
IRO Certificate No.: IRO 5055

Dear Ms. ____:

IRI has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, IRI reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of Independent Review, Inc. and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is licensed in chiropractic, and is currently on the DWC Approved Doctor List.

Your Right To Appeal

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

Sincerely,

Gilbert Prud'homme
General Counsel
GP:dd

REVIEWER'S REPORT
M5-06-0179-01

Information Provided for Review:

DWC-60, Table of Disputed Services, EOB's

Information provided by Requestor:

Office Notes 09/13/04 – 01/20/05

Daily Notes 09/13/04 – 03/16/05

PT Notes 12/17/04 – 03/23/05

FCE 02/01/05

Information provided by Respondent:

Correspondence

Designated Reviews

Clinical History:

Claimant underwent physical medicine treatments after sustaining injury at work on ____ when he attempted to un-wedge stones and put them in a cart.

Disputed Services:

97012 Mechanical traction, 98940 and 98941 chiropractic manipulation, 97124 massage therapy, 97112 neuromuscular re-education, 97530 therapeutic activities, 97110 Therapeutic exercises, and G0283 electrical stimulation - not marked as fee items - from 09/27/04 through 01/31/05.

Decision:

I partially agree with the determination of the insurance carrier in this case. The 97112 neuromuscular reeducation treatments are denied. The remaining disputed treatments - not marked as fee items - from 10/01/04 through 10/11/04 are approved. All treatments, examinations and procedures rendered after 10/11/04 are denied.

Rationale:

The *Guidelines for Chiropractic Quality Assurance and Practice Parameters* 1 Chapter 8 under “Failure to Meet Treatment/Care Objectives” states, “After a maximum of two trial therapy series of manual procedures lasting up to two weeks each (four weeks total) without significant documented improvement, manual procedures may no longer be appropriate and alternative care should be considered.” Therefore, there was support for a portion of the disputed treatments rendered during the 4-week period ending 10/11/04.

However, treatment after that date failed to fulfill statutory requirements 2 for medical necessity since the patient obtained no relief, promotion of recovery was not accomplished and there was no enhancement of the employee’s ability to return to or retain employment. Specifically, the records indicated that the patient’s pain was reported as the “same,” “no different” or “unchanged” on every date of service through 10/11/04. Moreover, the examination performed on 10/09/04 (as compared to 09/30/04) revealed that the claimant’s cervical flexion and right rotation ranges of motion remained unchanged, cervical right lateral bending decreased, lumbar right lateral bending decreased, and right SLR decreased. The examination performed on 01/20/05 (as compared to 10/09/04) revealed that the claimant’s cervical extension and left rotation ranges of motion had decreased, cervical left and right lateral bending remained unchanged, and lumbar right and left lateral bending ranges of motion decreased.

In regard to the neuromuscular reeducation services (97112), there was nothing in either the diagnosis or the physical examination findings on this patient that demonstrated the type of neuropathology that would necessitate the application of this service. According to a Medicare Medical Policy Bulletin 3, “This therapeutic procedure is provided to improve balance, coordination, kinesthetic sense, posture, motor skill, and proprioception. Neuromuscular reeducation may be reasonable and necessary for impairments which affect the body’s neuromuscular system (e.g., poor static or dynamic sitting/standing balance, loss of gross and fine motor coordination, hypo/hypertonicity). The documentation in the medical records must clearly identify the need for these treatments.” In this case, the documentation failed to fulfill these requirements, rendering the performance of this service medically unnecessary.

1 Haldeman, S; Chapman-Smith, D; Petersen, D *Guidelines for Chiropractic Quality Assurance and Practice Parameters*, Aspen Publishers, Inc.

2 Texas Labor Code 408.021

3 HGSA Medicare Medical Policy Bulletin, Physical Therapy Rehabilitation Services, original policy effective date 04/01/1993 (Y-1B)